Achieving collective impact

INTERSECTORAL HOMELESSNESS HEALTH STRATEGY 2020-2025

NSW GOVERNMENT

ST VINCENT'S HOSPITAL SYDNEY

CITY OF SYDNEY

phn CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

The Intersectoral Homelessness Health Strategy is a joint initiative of
South Eastern Sydney Local Health, Sydney Local Health District,
St Vincent's Health Network, Central and Eastern Sydney Primary Health Network,
Department of Communities and Justice - Sydney, South Eastern Sydney and
Northern Sydney District and City of Sydney.

Foreword

Access to safe and secure housing is a basic human right and critical to health and wellbeing.

Homelessness is one of the most severe forms of disadvantage and social exclusion that a person can experience, and reduces opportunities for educational, social, recreation, cultural and economic participation (Steen, 2018). Improving outcomes for people experiencing or at risk of homelessness is a priority across all three levels of government.

At a national level the Australian Government recognises that homelessness is an important issue and provides funding under the National Housing and Homelessness Agreement and through local agencies including the Central and Eastern Sydney PHN.

The NSW Government has an ambitious agenda for improving outcomes for people at risk of, or experiencing, homelessness. That agenda includes reducing homelessness across NSW through addressing the systemic drivers of homelessness (such as domestic and family violence), halving street homelessness by 2025, and supporting individuals to live safer, more stable and happier lives.

Local government plays a critical role in responding to the needs of people at risk of, or experiencing, homelessness. The City of Sydney's Council is committed to the primary prevention of homelessness and is directly responding to people experiencing homelessness, and supporting integration of homelessness services. More than one-third of people experiencing homelessness in NSW reside within the central and eastern Sydney geographical region. Each partner agency to this *Intersectoral Homelessness Health Strategy* has identified homelessness as a priority and are actively working within their agencies, as well as with non-government organisations and other partners to improve health outcomes for people experiencing or at risk of homelessness.

Homelessness causes or contributes to poor health. Rough sleeping, or living in inadequate, unsafe, or unstable short-term accommodation can cause or exacerbate mental and emotional health issues; increase risk of injury (due to violence); and make it difficult to manage chronic health conditions such as metabolic conditions or respiratory disease.

Likewise, **poor health and poor access to health care can cause homelessness** or make it difficult to sustain tenancies. This can take a variety of forms, such as untreated mental illness causing disruption to tenancies, or chronic physical illness contributing to poverty and thus difficulty sustaining a tenancy.

At present, people experiencing homelessness in our region:

- Have higher rates of chronic diseases and multi-morbidities, including post-traumatic stress disorder;
- Have poorer access to diagnosis, treatment and care;
- Have poorer access to primary and preventative care; and
- Are at risk of being discharged to homelessness from health services.

Together, our agencies share a commitment to improving health outcomes for people experiencing, and those at risk of, homelessness.

This *Intersectoral Homelessness Health Strategy 2020-2025* identifies our shared strategic priorities for improving health outcomes among people experiencing homelessness.

While each partner has its unique role and responsibilities in improving the health of people experiencing homelessness, we believe that the most significant gains will come from our six agencies working together on our shared priorities. Each of those priority action areas will be progressed collaboratively between the partners and other relevant stakeholders over the next five years.

Over the coming three years, this will include:

- **Enhancing the service system by:**
  - Improving access to the right care at the right time;
  - Strengthening prevention and public health; and
  - Increasing access to primary care;
- **Building the enablers by:**
  - Building workforce capability;
  - Establishing collaborative governance and shared planning.

In the period 2023-2025, we will consolidate these areas and increase focus on:

- Addressing the needs of priority populations at heightened risk of homelessness or poor outcomes;
- Trialing new models of care, new service models and new workforce models;
- Exploring the potential for place-based responses;
- Reviewing progress on addressing chronic disease and the prevention of blood borne viruses;
- Strengthening the relationship between Department of Communities and Justice, Land and Housing Corporation, Community Housing Providers and Health; and
- Scaling up existing work addressing the needs of people in Boarding Houses.

Together, these will enable us to achieve the quadruple aim of:

- Improving people's experience;
- Improving population level outcomes;
- Reducing the costs associated with health care; and
- Improving the experience of providing care.

We are proud of our joint efforts towards a truly integrated approach to improving health for people experiencing homelessness. We thank all those who have participated in the consultation process to inform the development of this Strategy, particularly people experiencing homelessness, and look forward to leading its implementation in the coming years.

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Acknowledgements

Development of this Strategy would not have been possible without the generosity and insight of people with lived experience of homelessness. Our thanks also go to the clinicians, service providers and senior leaders who contributed to the development of this Strategy. Your insights into the health needs of people experiencing homelessness were vital in shaping the priorities outlined in this Strategy.

This project has benefited enormously from the leadership and high-level governance provided by the Steering Committee, and the practical support provided by the Project Management Group. The members of the Steering Committee are listed at Appendix 6.

Contents

Consumer comments:

If your six organisations worked together, that would make a big difference

(Person experiencing homelessness)

Unless you know someone who can help you get to a specific program, you just lie there.

(Person experiencing homelessness)

Service provider comments:

Health and homelessness are inextricably linked. It's very difficult to remain healthy without safe housing, and it's very difficult to sustain a tenancy without good health and good access to health care.

(Senior Clinician)

Clinicians get frustrated at the lack of services available, and the cycle of hopelessness just gets perpetuated for the clinician as well as the person presenting.

(Senior Manager)

Unstable housing is a major driver of prolonged length of stay and readmission.

(Senior Mental Health Clinician)

The shift to NDIS and the winding up of essential community-based support services for people with severe mental illnesses ... has meant that a number of services have discharged client ... who have subsequently struggled to maintain their tenancy.

(Senior Program Manager)

I can't think of anything that ISN'T an issue in terms of access to health care for people experiencing homelessness.

(Senior Mental Health Clinician)

We have some excellent clinicians but the system ties both hands behind their back.

(Senior Leader, LHD)

It turns into something very emotional when you have to discharge someone back onto the streets ... especially someone who is young ... we've got a chance with that group to save them from lifelong homelessness but our options are limited...

(Senior Clinician)

Some people experiencing homelessness have limited ability to navigate the system without someone to support them the whole way.

(Senior Clinician)

We need continuity of care in the community – there has to be a link beyond Emergency Departments.

(Senior Clinician)

The cost of things being uncoordinated is huge. It is a huge cost to the individual and it's a huge cost to the agencies. We had one guy (whose) frequent presentations cost the system $120,000 in one year.

We need to identify people early and invest in flexible service models that actually meet the needs of this patient population.

(Senior Clinician)

Introduction

The Intersectoral Homelessness Health Strategy 2020-2025 describes the shared agenda for improving health outcomes for people experiencing, and at risk of, homelessness in our region. It has been jointly developed by:

- South Eastern Sydney Local Health District;
- Sydney Local Health District;
- St Vincent's Health Network;
- Central and Eastern Sydney Primary Health Network;
- Department of Communities and Justice, Sydney, South Eastern Sydney and Northern Sydney District; and
- City of Sydney.

The Strategy includes priorities to address the range of people experiencing homelessness across the region, including:

- People at risk of homelessness;
- People experiencing primary homelessness, that is, people without conventional accommodation (e.g. sleeping rough or in improvised dwellings);
- People experiencing secondary homelessness, that is, people who frequently move from one temporary shelter to another (e.g. emergency accommodation, youth refuges, 'couch surfing'); and
- People experiencing tertiary homelessness, that is, people staying in accommodation that falls below minimum community standards (e.g. boarding houses and caravan parks) (Chamberlain and McKenzie, 2002, cited in Homelessness Australia (2014)).

The partner agencies will work together to implement the priorities; and in doing so will also collaborate with the broader network of services and stakeholders, including people experiencing homelessness, Homelessness NSW, Specialist Homelessness Services, and other non-government/community managed organisations.

Our guiding principles

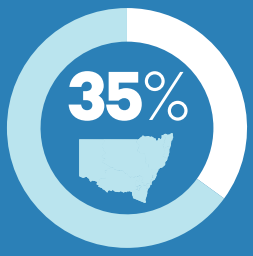
Our goal is to improve health outcomes for people experiencing homelessness.

Our efforts will be guided by our shared commitments to:

- Provide compassionate and non-discriminatory person-centred care;
- Reduce exits from health services into homelessness;
- Create pathways into health services that enable people to sustain their tenancy; and creating pathways into housing for people experiencing homelessness;
- Providing flexible models of care;
- Providing trauma informed care;
- Providing culturally safe care for Aboriginal people;
- Providing culturally responsive care for people from culturally and linguistically diverse backgrounds;
- Providing and facilitating access to the right care at the right time in the right way;
- Co-design and co-production with people experiencing homelessness; and
- Working in collaboration, through coordinated care between clinicians, strong pathways between services and a regional approach to improving outcomes and evaluating impact. A lead partner for each identified strategy has been identified to facilitate implementation and reporting across all partner agencies and other key stakeholders.

Overview of homelessness in our region

13,180
people experiencing homelessness in our region



NSW people experiencing homelessness live in our region

DRIVERS OF HOMELESSNESS

Poverty and financial disadvantage account for **21%** of homelessness in NSW

Undersupply of affordable and appropriate housing accounts for **25%** of homelessness in NSW

Domestic violence and relationship issues account for **34%** of homelessness

Mental health and substance use issues account for **7.5%** of homelessness

Other factors include:
inadequate transfer of care from government facilities, transition from custody, lack of support, and discrimination

PROTECTIVE FACTORS

- Employment
- Community connectedness
- Effective service system that provides integrated and coordinated care, and that intervenes early to address social determinants of health

KEY HEALTH ISSUES

- Serious mental illness
- Problematic alcohol and other drug use
- Trauma
- Brain injury
- Chronic disease

GAPS IN THE SERVICE SYSTEM

- Integration of the service system
- Access to primary care
- Access to post-crisis support and support for people experiencing secondary and tertiary homelessness
- Geographical reach of assertive outreach services
- Innovative models of care that deliver flexible, integrated care
- Workforce that routinely delivers respectful person-centred care

About homelessness in this region

This Strategy identifies priorities for improving health outcomes for residents within the geographic boundaries of Sydney and South Eastern Sydney Local Health Districts. This area includes Inner City Sydney, Inner West Sydney, Canterbury, Eastern Suburbs, St George and Sutherland. There were 13,180 people experiencing homelessness in this region on Census night in 2016. As such, this region is home to 35% of the state's homeless population.

Of note:

- The highest rates of homelessness for this region were in the Inner City area (37% of the population experiencing homelessness), followed by the Strathfield-Burwood-Ashfield area (15%);
- Rough sleeping was most common in the Inner City, but makes up only 5% of people experiencing homelessness in the region;
- Ten percent (10%) of those experiencing homelessness across the region were residing in supported/crisis accommodation on the night of the Census;
- Boarding Houses make up a significant portion of people experiencing homelessness in both the Inner West and Inner City (24% in total) and account for over half of those experiencing homelessness in the Eastern Suburbs (59%); and
- People living in 'severely' overcrowded dwellings form the most common experience of homelessness across most areas. Twenty two percent (22%) of the regional total was in the Inner City and Strathfield, Ashfield and Burwood areas.

According to data from the 2015 Homelessness Inner City Registry Week, people experiencing homelessness in the Sydney LGA[1] had been homeless for an average of 5.3 years. Of the 2015 Inner City Registry Week participants:

- One third had lived in Inner Sydney prior to becoming homeless; with 21% previously residing in Metropolitan or Greater Sydney, and 22% from elsewhere in NSW. Significantly, close to 10% resided outside of Australia before becoming homeless;
- Eighty two percent (82%) were male, 17% were female and 1% were transgender;
- Seventeen (17%) were Aboriginal and Torres Strait Islander (Homelessness NSW 2016).[1]

[1] It should be noted that the 2015 Inner City Registry Week participants are not representative of the entire population of people at risk of, or experiencing homelessness, across the region, and that this group contains much higher proportions of those sleeping rough and much lower proportions of those experiencing secondary and tertiary homelessness.

Drivers of homelessness

Homelessness is caused by a range of economic, social and personal circumstances. Data from Homelessness Australia (2014) shows that the key drivers of homelessness in NSW are:

- **Poverty and financial disadvantage** account for 21% of homelessness in NSW.
- **The undersupply of affordable and appropriate housing** accounts for 25% of homelessness in NSW. This includes the insufficient access to affordable accommodation across Sydney, as well as issues associated with inadequate or inappropriate dwellings. Of note, the Australian Housing and Urban Research Institute (AHURI) found that 210,000 new social housing properties would need to be built in NSW in the coming twenty years to meet current levels of demand (Lawson et al, 2018).
- **Domestic and family violence and relationship issues** account for 34% of homelessness. Women, including pregnant women and women with children, account for a significant proportion of those who are homeless
- **Mental health and substance use issues** account for 7.5% of homelessness.
- The remaining 13% of homelessness is caused by a range of other factors, such as inadequate transfer of care from government facilities (such as health services), transition from custody, lack of support, and discrimination (Homelessness Australia, 2014).

Key informants involved in the development of this Strategy noted that changes in funding and service models can also inadvertently contribute to increased risk of homelessness.

Individual protective factors, that is, factors that reduce a person's risk of homelessness – include employment and community connectedness. Having an effective service system that provides integrated and coordinated care, and that intervenes early to address social determinants of health and discrimination, also plays an important protective function.

The health needs of people experiencing homelessness

People experiencing homelessness have a higher prevalence of chronic (long term) conditions and often experience a higher burden of illness as a result of those conditions.

This is because:

- Some conditions can significantly increase the risk of homelessness;
- Homelessness can cause or exacerbate existing conditions (in particular depression, anxiety and post-traumatic stress disorder); and
- Homelessness can increase vulnerability to some conditions (trauma, injury, skin conditions, wounds, respiratory conditions, depression and anxiety).

More prevalent conditions include:

- Serious mental illness;
- Problematic alcohol and other drug use;
- Trauma, including childhood trauma and intergenerational trauma;
- Brain injury;
- Infectious/communicable diseases; and
- Chronic disease, including
  - Metabolic syndrome;
  - Cardio-vascular disease;
  - Obstructive Pulmonary disease;
  - Liver disease, including chronic viral hepatitis and advanced liver disease;
  - Oral health conditions;
  - Early onset ageing, with earlier onset of health issues including cognitive impairment, frailty, falls and incontinence; and
  - Cancers.

Key findings of the 2015 Homelessness Inner City Registry Week include:

- 53% of participants reported a **serious mental illness**;
- 72% of participants reported **problematic alcohol and other drug use**;
- Nearly 66% of participants reported having **both mental health issues and problematic alcohol or drug use**;
- 49% of participants reported a history of **trauma** (including emotional, physical, psychological, sexual or other trauma); and
- 29% of participants reported having a **brain injury** (Homelessness NSW, 2016).

Strategy on a page

Priority action areas 2020-2023

1 ENHANCING THE SERVICE SYSTEM

IMPROVING ACCESS TO THE RIGHT CARE AT THE RIGHT TIME

Develop and pilot an assessment tool to maximise early identification of people at risk of, or experiencing homelessness in health care settings; and support the development of locally appropriate tools in SVHN, SESLHD and SLHD.

Strengthen partnerships between housing services, health services and other organisations working with people experiencing homelessness.

Expand access to case coordination through supporting the development of new case coordination mechanisms and/or expanding existing mechanisms.

Increase access to case management among people at risk of or experiencing homelessness by facilitating access to the Mission Australia Home and Healthy Program and other case management services.

Strengthen integrated care across SESLHD, SLHD and SVHN through use of digital tools such as eMR and the patient flow portal.

Increase access to health care through increased health support for assertive outreach services including street-based outreach.

INCREASING ACCESS TO PRIMARY CARE

Provide Continuing Professional Development for General Practitioners, practice nurses and other primary care practitioners.

Build leadership and capability across the primary care sector.

Provide practice support for GPs working with people experiencing homelessness.

Explore the feasibility of trialing new models of primary care in key locations, including novel models to improve the service integration for people experiencing homelessness.

Enable and support GP registrars to work in homelessness health clinics during their training.

STRENGTHENING PREVENTION AND IMPROVING PUBLIC HEALTH

Develop a coordinated response to disease prevention among people experiencing, or at risk of, homelessness across the region.

2 BUILDING THE ENABLERS

BUILDING WORKFORCE CAPABILITY

Develop targeted training to address key gaps in workforce development across the region

ESTABLISHING COLLABORATIVE GOVERNANCE AND SHARED PLANNING

Establish a Senior Collaborative Alliance

Priority Action Areas 2020 - 2023

The NSW response to homelessness is rapidly evolving, as the NSW Homelessness Strategy is progressively implemented. In that context, this Strategy sets our joint service priorities for improving health outcomes for people experiencing primary, secondary and tertiary homelessness over the coming three years. A mid-term review in 2023 will identify early gains and establish priorities for 2023-2025.

In the next three years our joint efforts will focus on building the regional approach to:

Working across these domains concurrently and collaboratively will allow us to achieve impact at the individual, population and system level.

For each priority action area, a number of strategies have been developed and a lead partner identified. The role of the lead partner is to facilitate the implementation planning and coordinate activity and reporting across all partner agencies and other key stakeholders.

Improving access to the right care at the right time

As outlined earlier in this *Strategy*, people who are experiencing homelessness have higher burdens of disease in relation to physical health, mental health, complex trauma, psychosocial wellbeing, and drug and alcohol. In that context, linkages to health, housing and psychosocial supports are essential.

However, people experiencing homelessness in general have a difficult journey through the health care system. They are over-represented among those who access health care via Emergency Departments and the Ambulance Service, are more likely to access care when acutely unwell, and often have multiple chronic, unmanaged health conditions.

Improving health outcomes, and access to the right care at the right time, requires a multi-faceted response, including:

- Identifying people at risk of, or experiencing homelessness at the earliest opportunity;
- Linking people to the care that they need at the earliest possible opportunity;
- Providing access to ongoing support from the appropriate range of services (including mental health, psychosocial support and housing providers) at each stage of a person's journey;[2]
- Providing care coordination to assist people to navigate the health and housing systems and receive the support they require[3] ; and
- Addressing barriers to engagement or coordinated care (including working with clients to gain informed consent for information sharing and collaboration between agencies).

Strategies

1.1 Develop and pilot an assessment tool to maximise early identification of people at risk of, or experiencing homelessness in health care settings; and support the development of locally appropriate tools in SVHN, SESLHD and SLHD.

Lead Partner: *St Vincent's Health Network*

1.2 Strengthen partnerships between housing services, health services and other organisations working with people experiencing homelessness, including maximising the early identification of and responses to social housing tenants at risk of homelessness due to health issues; strengthening referral pathways and information sharing between agencies.

Lead Partner: *Department of Communities and Justice.*

1.3 Expand access to case coordination through supporting the development of new case coordination mechanisms and/or expanding existing mechanisms. In particular, we will focus on providing early intervention with those at risk of homelessness; addressing geographic gaps in case coordination; and strengthening care coordination for people experiencing secondary and tertiary homelessness.

Lead Partner*: Department of Communities and Justice*

1.4 Increase access to case management among people at risk of or experiencing homelessness by facilitating access to the Mission Australia Home and Healthy Program and other case management services.

1.5 Strengthen integrated care across SESLHD, SLHD and SVHN through use of digital tools such as eMR and the patient flow portal.

Lead Partners: *South Eastern Sydney Local Health District*

1.6 Increase access to health care through increased health support for assertive outreach services including street-based outreach.

Lead Partner: *Department of Communities and Justice*

[2] This can reduce risks of homelessness, assist individuals to transition out of homelessness into accommodation and improve tenancy sustainability for people with previous experience of homelessness.

[3] There are a number of existing mechanisms which assist individuals to access care, including the Homelessness Assertive Outreach Response Team (HART), the Eastern Suburbs Homelessness Assertive-Outreach Collaboration (ESHAC), the Woolloomooloo Integrated Services Hub, the Ashfield and Newtown Homelessness Assertive Outreach Collaborations and the Inner West Homelessness Assertive Outreach Collaboration – Case Coordination Meeting. (See Appendix 5 for more detailed information about existing mechanisms and the work of each partner agency). However, there are significant gaps in capacity, particularly in relation to early intervention; in some geographic areas outside the Central Business District; and for people experiencing secondary and tertiary homelessness.

Strengthening prevention and public health

Disease prevention and public health initiatives are critical in reducing preventable burden of disease and improving population health outcomes.

There are already a number of local **public health initiatives** in place for people experiencing homelessness. These include annual programs to distribute influenza vaccines, targeted initiatives to address strategic priorities (e.g. hepatitis C health promotion), and responses to extreme weather.

There are also local arrangements for managing public health emergencies such as outbreaks of communicable diseases in specialist homelessness services.

There are, however, opportunities to improve population-level outcomes, and reduce gaps in coverage, through a more coordinated, regional response.

Strategies

In the coming three years we will:

2.1 Develop a coordinated response to disease prevention among people experiencing, or at risk of, homelessness across the region.

***Lead Partner**: St Vincent's Health Network*

Increasing access to primary care

Primary care includes the care provided by General Practitioners, primary health care nurses, specialist primary health care services, and allied health as well as the central and unique role played by the Redfern Aboriginal Medical Service.

Primary care is a critical site for preventative health care, early diagnosis and management of acute and chronic disease and access to specialist health care. Primary health care providers play a key role in coordinating the health care provided to individuals with complex needs, enabling patients to access the right care at the right time and place, and in doing so, avoid unnecessary hospitalisation.

There is a range of primary care services in the region with a dedicated focus in providing holistic care to people experiencing homelessness. These include:

- General Practices (providing patient-centred care for homelessness);
- Homeless Health Service at St Vincent's Hospital;
- Aboriginal Medical Service Redfern;
- Kirketon Road Centre;
- Mission Australia Clinic (MAC); and
- Primary health care clinics at the Matthew Talbot Hostel and the Exodus Foundation.

There is clearly potential to both increase the number of general practices and allied health practitioners working with this population, and to better link existing services to specialist public facilities.

In addition, an emerging body of evidence points to the potential to improve patient outcomes through new models of primary care.

Strategies

3.1 Provide Continuing Professional Development for General Practitioners, practice nurses and other primary care practitioners on the skills and knowledge required to engage and care for people at risk of, or experiencing, homelessness.[4]

Lead Partner: *Central and Eastern Sydney Primary Health Network*

3.2 Build leadership and capability across the primary care sector.

Lead Partner: *Central and Eastern Sydney Primary Health Network*

3.3 Provide practice support for GPs working with people experiencing homelessness.

Lead Partner: *Central and Eastern Sydney Primary Health Network*

3.4 Explore the feasibility of trialing new models of primary care in key locations, including novel models to improve the service integration for people experiencing homelessness.

Lead Partner: *Central and Eastern Sydney Primary Health Network*

3.5 Enable and support GP registrars to work in homelessness health clinics during their training.

Lead Partner: *Central and Eastern Sydney Primary Health Network*

[4] This will include upskilling general practices to ask patients about housing security or risk of homelessness and strategies to provide appropriate care and to continue to promote the Homeless Health Pathway as a tool for care planning.

Building workforce capacity

There is a diverse and sizable workforce responsible for achieving the goals of this Strategy. Across the six partner agencies, this includes: specialist homelessness staff in NGOs, social housing providers and Department of Communities and Justice; General Practitioners and primary health care nurses; Council employees; specialist homelessness health staff; and clinicians, ward and administrative staff and health service managers from a range of clinical streams/services (including Emergency Departments, Mental Health, Drug and Alcohol and Social Work).

We are committed to:

- Increasing the knowledge, skills and confidence of the workforce in engaging with and responding to the health needs of people at risk of/experiencing homelessness;
- Increasing the understanding of and capability to provide trauma-informed care;
- Building knowledge and understanding of the broader service system among each segment of the workforce, so that for example health staff are more confidently able to connect people to housing services, and housing services are more confidently able to connect people to the relevant health service; and
- Building cross-sectoral relationships that facilitate referrals and care coordination.

There is a need to provide a range of training to achieve this, including introductory training and more advanced or issue-specific training. In order to facilitate mutual understanding and strengthen referral pathways and informal connections, and reduce duplication, there will be a joint investment in coordinated, cross-agency workforce development.

The key principles that underpin that workforce development are:

- Workforce development should address the local context;
- Workforce development should identify the broader factors that affect the health of people experiencing homelessness (e.g. the social determinants of health, relevant aspects of the policy and service context);
- There should be a mixed methods approach, tailored to the needs of the audience; and
- People with lived experience should, wherever possible, co-design and co-produce that training; and should be supported to develop skills to participate fully in that process.

Strategies

In the coming three years we will:

4.1 Develop targeted training to address key gaps in workforce development across the region.[5]

Lead Partner: *South Eastern Sydney Local Health District*

[5] Including providing support to new employees to develop knowledge and understanding of relevant services and new initiatives to enable better service collaboration.

Establishing collaborative governance and shared planning

Ongoing collaboration will be critical to the implementation and success of this Strategy and achieving our shared goal of improving the health of people experiencing homelessness.

There are currently many effective collaborations in place at the service-provider/clinician level and the service-service level. However, the service system overall is fragmented, with limited oversight of the full breadth of initiatives underway, and limited opportunities for the six partners in this Strategy to engage in joint planning and implementation across organizational and geographic boundaries. Where coordination mechanisms do exist, they may not include the full range of partners, or cover the full region covered by this Strategy.

Strategies

In the coming three years we will:

5.1 Establish a Senior Collaborative Alliance.

The six signatories to this Strategy will be permanent, standing members of the Senior Collaborative Alliance. Other partners (such as Non-Government Organisations) may also participate depending on the priorities of the Alliance in each phase.

The purpose of the Alliance is to:

- Advocate for state and national policy that supports improved health outcomes for people experiencing homelessness;
- Leverage the existing knowledge, capacity and reach of the six partner agencies;
- Collaboratively plan for new initiatives or evaluate and scale up successful pilots, including consideration of opportunities for joint funding or co-commissioning new initiatives;
- Enable joint consultation with key leaders as to new initiatives under consideration;
- Monitor progress toward the goals of this Strategy;
- Convene an Annual Forum to bring together partners in this Strategy to profile emerging priorities and share effective practice;
- Oversee this Strategy, including ongoing monitoring of progress towards the goals of this Strategy and evaluation of outputs and outcomes; and
- Advocate to key state and national partners on shared priorities.

SLHD and SESLHD will share chairing and secretariat responsibilities in the first instance.

The Alliance will function as a sub-group of the Regional Coordination Group.

Joint Lead Partners: *South Eastern Sydney Local Health District and Sydney Local Health District.*

Priority Action Areas 2023 - 2025

The priorities outlined above will make substantial progress toward improving health outcomes and access to health care among people experiencing homelessness.

In 2023-2025, we will build on those foundations through:

- Developing targeted responses to **priority sub-populations** of people experiencing homelessness, including Aboriginal people, young people, women and families;
- Reviewing progress on addressing **chronic disease** and the **prevention of blood-borne viruses** among people at risk of, or experiencing, homelessness;
- Trialing **new models of care** for addressing mental health and homelessness;
- Strengthen partnerships between DCJ, Land and Housing Corporation, Community Housing Providers and Health to address the **shortage of suitable accommodation** and develop new service models;
- **Collaborating** with people with lived experience (co-design and co-production);
- **Exploring the potential for place-based responses** in those areas with a higher concentration of people who have been housed following a period of homelessness.

  This could include:

  - Identifying opportunities to collaborate with a broader range of partners, including neighbourhood centres and community centres, in building community connectedness and resilience;
  - Scaling up existing work addressing the needs of people in Boarding Houses;
  - Collaborative work to strengthen community connectedness and resilience in disadvantaged areas, and thus reduce social isolation;
  - Co-location of services in areas with a high prevalence of disadvantage through local hubs or one-stop shops;
- Exploring the potential for **co-commissioning** of new services and/or jointly trialing new models of care; and
- Expanding and evaluating **new workforce models**, such as the involvement of peer or community workers in improving health outcomes for people experiencing homelessness.

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Appendices

Appendix 1
Definitions

Homelessness

A person is considered homelessness if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations (Australian Bureau of Statistics, 2012).

Integrated care

Integrated care is a model of care or service model which integrates the functions and processes of participating systems across the whole of a person's health needs, from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and families.

The aim of integrated care is to have care centred around the person, and to help people with complex needs get the care they need when they need it.

Care Coordination

Deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency. Patients enrolled into the integrated care program are monitored and supported for the duration of the intervention. A key aim is to empower patients to self-manage, understand their illness, and seek additional support and intervention when required (from https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx).

Case conferencing

A case conference is a meeting/discussion held between service providers from different disciplines or organisations to discuss an individual's needs and to coordinate care.

Case management

Case management is the "co-ordination of community-based social, mental health and medical services based on unmet needs for vulnerable populations facing long-term challenges and needing extended care." (Ko et al 2013).

Co-location of services

Co-location of services refers to two or more agencies operating out of a single physical space. This is often referred to as 'a hub' or 'a one-stop shop'.

Appendix 2
Priority sub-populations

Specific sub-populations of people experiencing homelessness have been identified as being at heightened risk of poorer outcomes and these are identified below as priorities for the LHD. It should also be noted that issues for sub-populations are complex and overlapping and many people experiencing homelessness are members of more than one sub-population. Priorities for the partners in this Intersectoral Homelessness Health Strategy include:

Aboriginal people

Aboriginal people are vastly over-represented among those experiencing homelessness (particularly primary homelessness).

Aboriginal people who are homeless may have first experienced homelessness at a younger age than other homeless people who are non-Indigenous. As such, there are more homeless Aboriginal people under 18 (42%) than non-Indigenous people (20%) (AIHW, 2014). Aboriginal women are over represented in Specialist Homelessness Services, with domestic violence the most commonly reported reason for seeking assistance (AIHW, 2014).

There are a range of factors which contribute to the higher prevalence of homelessness among Aboriginal people, including structural drivers (the ongoing impacts of the Stolen Generation and dispossession of land; legislative discrimination; poverty; intergenerational trauma; over representation in out-of-home-care and the juvenile justice system), the limitations of the service system (e.g. the lack of culturally appropriate housing, creating a risk of overcrowding when people are given a tenancy) and individual risk factors.

Aboriginal people experiencing homelessness are a diverse population but many experience multifaceted disadvantage, including higher rates of socio-economic disadvantage; higher prevalence of trauma (including intergenerational trauma), mental health conditions, chronic disease (e.g. cardiac, respiratory, diabetes, and cancer), domestic violence and problematic drug and alcohol use.

It is well-established that accessing health care can be more difficult for Aboriginal people, owing to a range of historical and systemic factors, including racism and fear of racism. These difficulties are amplified by homelessness.

Women

There is growing recognition of the specific experiences and needs of women experiencing homelessness. Women at particular risk include:

- Women who are experiencing homelessness due to domestic and family violence;
- Older women who are experiencing homelessness due to a range of factors, including poverty, disability experience of elder abuse or family breakdown;
- Young women;
- Aboriginal women;
- Pregnant women and women with children; and
- Women on precarious Visas.

Specific additional issues for women experiencing homelessness include:

- Poor access to the continuum of care (from routine screening such as breast and cervical screening, to diagnosis to treatment and care);
- Vulnerability to violence, abuse and exploitation;
- Access to antenatal care for pregnant women experiencing homelessness;
- Sexual and reproductive health (particularly for young women experiencing homelessness); and
- Chronic disease, including higher rates of heart disease, osteoporosis and earlier onset of the health issues associated with ageing.

Many women experiencing homelessness are accompanied by children and require access to services which can support both them and their children. This may include support with addressing the physical health needs of children (such as Child and Family Nursing), as well as counselling, employment support and other support for mental health and social and emotional wellbeing. It is acknowledged that many Specialist Homelessness Services target men, and there are relatively fewer services for women and children. There are few services that can provide crisis and temporary accommodation to women who have substance use and/or chronic mental health issues and/or who do not have access to Medicare.

Women and children escaping domestic and family violence

Women and children escaping domestic and family violence present a particularly complex sub-population. Although there are a number of state and national policies, strategies and programs to facilitate support for women and children escaping domestic and family violence, those who are simultaneously experiencing homelessness are faced with additional barriers to accessing essential health, housing, legal and social services.

Young people

Young people are an over-represented and growing proportion of those experiencing homelessness in NSW, with the 2016 Census showing that the rate of homelessness for young people aged 19-24 increased by 92% from 2011-2016. That data shows that 60% of homeless young people aged 12-24 were living in severely overcrowded dwellings, but that there had been a 31% increase in the number of young people sleeping rough from 2011-2016 (YFoundations, 2018).

Around 60% of young people in Specialist Homelessness Services have been in the Out of Home Care system. This group has been identified as experiencing multiple vulnerabilities; and as being at higher risk of progressing to long term homelessness.

Access to the right care at the right time can be a particular issue for young people as:

- Medicare activity-based funding models and appointment-based service models may not be a good fit for how young people experiencing homelessness engage with services;
- The risk of falling through the gaps when transitioning from paediatric and/or youth to adult services, particularly given that different services have different cut off ages;
- Young people experiencing homelessness may not place a high priority on health and access to health services, owing to multiple competing priorities;
- Youth homelessness services may place a lower priority on health care than on other issues;
- There is insufficient capacity within the system to meet the needs of the population of young people experiencing homelessness; and
- Young people who identify as LGBTIQ often experience stigma and discrimination which is an additional barrier to engaging with health services.

People from culturally and linguistically diverse backgrounds

People from culturally and linguistically diverse backgrounds are overrepresented in those living in severely overcrowded dwellings. In 2016, 54% of this group were born in an Asian country, compared with 33% born in Australia. People from culturally and linguistically diverse backgrounds who experience homelessness may find it difficult to access health care due to:

- Socio-economic disadvantage;
- Language and cultural barriers;
- Cultural shame and stigma related to homelessness;
- Issues with eligibility associated with visa status; and
- Lack of knowledge about services available and how to navigate those services.

People who have arrived in Australia as refugees or asylum seekers may find it particularly difficult to access health care as well as homelessness support services.

It is essential that people who do not speak English well are offered language support through professional interpreters when accessing health and community support services.

People with disability

People with disability (including people with intellectual disability, psychiatric disability and people with traumatic brain injury) are over-represented among those experiencing homelessness. In general, people with disability have poorer health outcomes and greater difficulty obtaining health services, and this is exacerbated by homelessness. Issues for this population can include:

- Higher prevalence of some physical and mental health conditions;
- Under-diagnosis of existing disability, in particular traumatic brain injury;
- Limited understanding across health services as to effective communication with people with disability (NSW Health, 2012);
- Less developed health literacy;
- Socio-economic disadvantage;
- Lack of clarity about services and how to access those services for which they are eligible, particularly given the changes to the service landscape associated with the current disability reforms and introduction of the NDIS;
- Disability service gaps created by the withdrawal of Ageing Disability and Home Care (ADHC) and subsequent lack of services for people with a physical or psycho-social disability who are not eligible for the NDIS but have a disability and require disability supports; and
- Thin market for disability support services created by the free market-based system, in particular for people with complex needs.

People with current or historical problematic substance use

Some 72% of 2015 Homelessness Inner City Registry Week participants reported a history of problematic substance use. This group is diverse and includes both people using substance use to self-medicate past trauma and/or mental illness, and people for whom problematic substance use was the main factor in loss of tenancy.

Problematic alcohol and other drug use can significantly impact on health and long-term wellbeing, due to its association with acquired brain injury, liver disease, oral health issues and skin conditions.

At the same time, problematic substance use can preclude access to or sustained engagement with health care and housing supports, due to:

- Stigma associated with problematic substance use;
- Self-exclusion, due to either diminished trust in service providers, or internalised stigma; and
- Eligibility criteria that preclude people with active substance use

People leaving Juvenile Justice and Department of Corrective Services facilities

People exiting gaol are significantly over-represented among those experiencing homelessness, with some 53% of NSW Homelessness Inner City Registry Week respondents indicating that they had been in prison (Homelessness NSW, 2015). Health issues for this population can include:

- Higher prevalence of some physical and mental health conditions, as well as substance use disorders;
- Disruptions in access to care following the transition from Justice Health to community providers; and
- Variable health literacy and knowledge/skill in navigating health services.

Older people experiencing homelessness

People who are homeless have an increased likelihood of experiencing the effects of ageing more rapidly than others in their age cohort. This is often exacerbated by pre-existing physical and mental health conditions. As such, the term 'older people' in this context refers to those aged 50 years and over, and 45 years and over for Aboriginal people.

Health issues for older people experiencing homelessness include:

- Increased risk of falls;
- Vulnerability to assault and prolonged physical recovery from injuries;
- Declining cognition resulting in increased difficulty navigating complex systems and remembering important appointments;
- Declining physical health; increased health needs but difficulty in accessing appropriate age-related services; and
- High prevalence of chronic disease and mental health conditions

Accessing the appropriate combination of housing and support services can be difficult for older people experiencing homelessness. This is because residential aged care may not be an appropriate location for someone with lived experience of homelessness; and the 1997 Aged Care Act does not recognise homelessness as a special need under the Act.

There are, however, a number of initiatives which are intended to address the specific needs of older people experiencing or at risk of homelessness, including:

- Provisions for older/prematurely aged people who are homeless or at risk of homelessness to access the Assistance with Care and Housing Program (My Aged Care Assessment Manual, 2018);
- Specific home care packages for older people experiencing homelessness. These operate as group homes in NSW Housing properties, with support provided by Uniting and Catholic Health Care; and
- Residential aged care facilities specifically catering for older people with a history of homelessness, including Charles Chambers Court and Annie Green (Mission Australia) and Frederick House (St Vincent de Paul), with a new facility in Darlinghurst currently under construction by Hammond Care.

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

A range of Australian research has found that LGBTI people are more likely to have ever experienced homelessness than heterosexual people in Australia. McNair et al (2017) concluded that there were personal and structural factors related to being LBGTIQ that contributed to risk of homelessness, including:

- Violence and harassment resulting from homophobia, biphobia and/or transphobia, and explicit discrimination;
- Ignorance;
- Personal vulnerability, including family conflict, childhood sexual assault, mental health and substance use issues.

McNair et al further note that responding appropriately to the needs of LGBTIQ people at risk of, or experiencing homelessness, requires:

- Service providers to understand the experience and needs of LGBTIQ people and to demonstrate inclusivity; and
- Capacity to identify and refer to appropriate housing pathways for LGBTIQ people.

Carers

People experiencing homelessness may be carers. They may require specific supports and services to assist them in their caring role, and/or additional supports for the person for whom they care while until they are able to find appropriate accommodation. Carer involvement may strengthen discharge planning and facilitate engagement with community care and support services. Carers of people experiencing homelessness may also have significant needs in relation to information, support and their own health needs.

Appendix 3
Access to and experience of care

While there is no comprehensive data on the journeys of people from homelessness to sustainable tenancies, the 2015 Homelessness Inner City Registry Week Report (Homelessness NSW, 2016) concluded that:

- **14% of people just need housing they can afford**
- **51% need short term support plus housing they can afford**
- **35% require intensive support plus housing they can afford. It should be noted that a higher proportion of Aboriginal and Torres Strait Islander people (54%) meet the threshold for requiring both long term support and affordable housing.**

Each of these populations require different responses from health, housing and other services.

Available data, and reports from key informants, indicate that access to health care varies by geography, by sub-population and by clinical need. Interestingly, people experiencing homelessness tend to be over-represented in accessing some clinical streams/services and in general have poorer access to other streams/services:

- NSW Homelessness Inner City Registry Week participants reported having multiple and varied interactions with the health system in the 6 months prior, including:
  - A total of 4,097 interactions with the crisis service system, equivalent to 8 per person
  - 1,007 trips to Accident and Emergency (equivalent to nearly 2 visits per person in the six month period)
  - 527 trips in an Ambulance (equivalent to 1 ambulance trip per person in the six month period) and
  - 376 periods of hospitalisation.
  - Women and Aboriginal participants were over represented among those who presented at Accident and Emergency, and among those who had travelled in an ambulance.
- People experiencing homelessness account for **14% of patients** at St Vincent's Hospital (Darlinghurst);
- The most recent SLHD Discharge to Homelessness Audit found that some **22% of patients admitted to the Adult Mental Health Services** in Sydney Local Health District had unstable housing (SLHD, 2018); and
- The SESLHD Homelessness Data Project (SESLHD, 2013) found that 1.5% of clients accessing SESLHD services were homeless. Aboriginal people constituted 11% of clients experiencing homelessness. And, of those clients identified as homeless, 87% were seen by Drug and Alcohol, Mental Health, Kirketon Road Centre and Emergency Departments.

Barriers to accessing the right health care at the right time

People experiencing homelessness encounter a range of barriers to timely access to care, and often have sub-optimal experiences of care. These barriers can include both personal factors and barriers within the service system.

Systemic barriers include:

Capacity

- **Insufficient capacity** to address presenting and underlying conditions. AIHW, in their specialist homelessness report notes that, nationally:

  > *"In 2017–18, on average, there were 236 requests per day which were unable to be met (equivalent to a total of 86,100 requests over the year). ...Mental health services, including psychological, psychiatric and mental health services, were one of the most common specialised services identified as needed by clients; however, these needs were frequently unmet with around 3 in 10 clients (32%) neither provided nor referred these services. Similarly, over one-third of the clients identifying a need for disability services (37%) or drug and alcohol services (35%) did not have their needs met, however, overall, these services were less needed that mental health services." (AIHW).*

- **Uneven geographical spread of services** targeting people experiencing homelessness, leading to people not receiving services or travelling/moving centrally to access services in the inner city (SHCN, 2018).

Models of care

- Many people experiencing homelessness have **multiple co-morbidities** and thus require coordinated rather than single-stream clinical care.
- **Fragmentation of the service system**, with services focused on providing shelter (e.g. boarding houses) not always having a mandate or the skills to address social and health needs (SDR, p. 4)
- **Service models** which are a poor fit for the health and access needs of this population, including complicated referral processes, strict eligibility criteria, and reliance on appointment times (rather than drop in):

  > *"lack of flexibility in service delivery, insufficient focuses on care co-ordination, assertive follow up and integrated care; and lack of provision of trauma informed care ... (people experiencing homelessness) can also experience difficulty managing structured appointment times."*
  > (Sydney Health Community Network, 2018).

- **Barriers to accessing General Practice** can include both personal and practical barriers, as well as perceptions of/fear of being judged (Davies and Wood, 2018). A number of informants in the consultation processes highlighted that many people experiencing homelessness have limited engagement with a single General Practitioner and/or General Practice and thus have poorer access to preventative care and ongoing management of chronic diseases.
- An overreliance on **emergency departments and Ambulance services**, and a pattern of **presenting in crisis or acute need** (Davies and Wood, 2018).

Skills, knowledge, values and attitudes of service providers

- The skills and capability of health staff, including primary care providers: *"Health service staff may feel uncomfortable communicating with people experiencing homelessness and this can create barriers to either access or retention"* - SESLHD1 p.16.
- Mistrust of health services, due to **previous traumatic experiences in hospital settings** or within health care. **Trust and continuity** are important for clients:

  > *"During project consultations and informal conversations with people who were rough sleepers they were asked whether or not they used mental health services, which were often more physically and geographically accessible, respondents explained that they used services, for any health issue where they felt safe, understood and respected, where they trusted the provider and where they could see the same person(s) rather than a different person/provider each time"*
  >
  > (Sydney Health Community Network, 2018).

- Specific barriers related to **discriminatory attitudes and practices**, which can affect people experiencing homelessness in general, as well as specific discrimination toward people with disability, LGBTQ people, young people, CALD people and people who currently or previously inject drugs.

Practical barriers

- **Documentation issues.** Many people experience difficulties receiving and maintaining documentation necessary for health care access (e.g. Medicare cards, Health Care cards, and correspondence regarding appointments). This can be an issue for people with no fixed address but may also be an issue for people with limited privacy in overcrowded accommodation.
- **Individual skills** in accessing and navigating the system, and lack of awareness of available services.
- Reduced capacity to **manage chronic conditions** (e.g. diabetes) due to sleeping rough and moving around:

  > *"In addition to an increase in lifestyle risk factors, experiencing homelessness may limit people's ability to manage certain physical conditions. For example, homelessness limits the ability of people to access and manage diabetes medications that require refrigeration and sterile environments for injecting, as well as a healthy balanced diet that minimises risk of diabetic shock (hypoglycemia)"* - AAEH p.42

- Other **practical barriers** such as financial and transport difficulties (Sydney Health Community Network, 2018)

Personal factors

- Health and health care may be a **lower priority** for a person experiencing homelessness, given the more urgent need for shelter, safety and food.

Transitioning from care

Transitioning from care is a key opportunity to maximise a person's protective factors and resources, and ensure that individuals are connected with the health, housing and social services that they require in the community. At the same time, transitioning from care is a time of heightened vulnerability to homelessness.

In November 2017, the Sax Institute brokered an Evidence Check rapid review on homelessness at transition (Conroy and Williams, 2017). That review examined six transitions or pathways:

- Young people leaving out-of-home-care
- Young people leaving juvenile justice
- People leaving prison
- People leaving hospital
- People leaving mental health facilities
- People leaving social housing

Key findings of that study included:

- Risk is likely to be heightened in the first year following exist from a government service
- For **young people leaving out-of-home care**, the most consistently reported risk factor for homelessness was placement instability, with a number of studies also poor support networks, and health problems (physical and mental health)
- For **people leaving hospital**, early identification and appropriate discharge planning would lessen the risk of an individual being discharged to homelessness, but that discharge planning processes and models can only be effective when there are housing and support options available in the community
- For **people leaving mental health facilities**, there was moderate evidence for both improved discharge planning (through a variety of models, including providing housing and income support on-site in the psychiatric ward; linking patients with a housing case manager prior to discharge; or linking patients with a specialist case manager post-discharge); and supported housing models. In particular, the authors note the 'superior outcomes with regard to housing stability' achieved via Housing First.

There are a number of key Ministry of Health documents which address the risks and opportunities associated with transitions[6] :

- The *NSW Health Transfer of Care from Mental Health Inpatient Facilities (PD 2016_056)* specifies that comprehensive assessment of a patient – including assessment of actual or risk of homelessness – should be completed on admission, and that facilities must then complete Transfer of Care Plans that address the consumer's needs, including needs relating to housing, accommodation and support; and provide referrals to relevant accommodation and accommodation support well in advance of the consumer leaving the inpatient unit.
- The *NSW Health Departure of Emergency Departments Patients (PD 2014_025)* specifies that prior to discharge, EDs must make every effort to identify and manage potential risks to the patient, including assessment and referral related to homelessness.
- The *NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals PD 2011_015* specifies that all departments, including Emergency Departments, must have guidelines in place for transfer of care for at-risk patients.

There are opportunities to build on these requirements in relation to people experiencing homelessness who are patients in health facilities.

[6] Both NSW *Transfer of Care from Mental Health Inpatient Facilities* and *NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* are under review. The revised Policy Directives will form part of the whole-of-government framework for reducing exits to homelessness from government facilities

Appendix 4
Strategic Context

There are a range of policy frameworks and strategic initiatives oriented to improving health outcomes for people experiencing homelessness.

Policy Frameworks

There is not currently either a state or national policy specifically focused on improving health outcomes for people experiencing homelessness. The Mental Health Branch of the NSW Ministry of Health does, however, play a lead role in supporting whole-of-government policy and funding specific initiatives to improve health outcomes among people experiencing homelessness.

The NSW Homelessness Strategy 2018-2023

This *Strategy*, which is led by the Department of Communities and Justice, sets out the NSW Government's commitments for preventing homelessness and improving the response to those experiencing homelessness. The Strategy has three focus areas:

- Identifying people who are vulnerable early;
- Providing better support and services; and
- Making the system simpler, more integrated and person-centred.

The *Strategy* has a range of implementation initiatives, including the review and updating of the Multi-Agency Client Transition Planning to Prevent Homelessness initiative, the purpose of which is to strengthen NSW Government agencies' transition planning policies and practices for priority cohorts, including people exiting health services, including Justice Health services.

In addition, the *NSW Homelessness Strategy 2018-2023* links closely to other key reforms led by DCJ, including Future Directions for Social Housing in NSW (which aims to increase the supply of social housing in NSW), and Their Futures Matter (which aims to develop a coordinated service system for vulnerable children and families).

NSW Domestic and Family Violence Blueprint for Reform 2016-2021: Safer Lives for Women, Men and Children

The Blueprint sets out the directions and actions to reform the domestic violence system in NSW over the five years 2016-2021.

The Blueprint provides the framework for building an effective system that addresses the causes and responds to the symptoms of domestic and family violence.

It includes strategies to prevent domestic and family violence, intervene early with individual and communities at risk, support victims, hold perpetrators to account, and improve the quality of services and the system as a whole.

NSW Domestic and Family Violence Prevention and Early Intervention Strategy 2017-2021

This Strategy sets the direction for the way NSW Government agencies, non-government organisations and communities, design and implement prevention and early intervention strategies over the four years 2017-2021.

Funding and strategic context

There are substantial changes underway that have the potentially to affect health outcomes for people experiencing homelessness:

National Disability Insurance Scheme

The NDIS is now fully implemented across NSW. The purpose of the NDIS is to provide people with disability with the support that they need, and choice and control over that support. In this context, the NDIS is relevant both for its overall support for people with disability (some of whom may be experiencing homelessness) and specifically its support for people with psycho-social disability.

The roll-out of the NDIS has brought new opportunities for some people experiencing homelessness, as it has provided access to a fuller range of services. For others, however, the roll-back of state-funded services that has accompanied the introduction of the NDIS has reduced their access to care and support in the community.

Addressing the intersecting roles and responsibilities of the health, housing and disability service system will be an ongoing challenge in the coming years.

End Street Sleeping Collaboration

In February 2019, the NSW Government, the City of Sydney, the Institute of Global Homelessness and a number of non-government partner organisations entered into a joint commitment to reduce rough sleeping. The End Street Sleeping Collaboration project has set targets to reduce street sleeping in the City of Sydney by 25 per cent by 2020, across NSW by 50 per cent by 2025, and to work towards functional zero street sleeping in NSW by 2030.

A Connections Week, conducted in November 2019 has surveyed people experiencing homelessness and will be used to establish a By-Name list of people who are street sleeping in the inner city. This list allow improved coordination of services for individuals as well as identifying strategies that could be implemented to prevent homelessness.

Home and Healthy

This social impact investment includes a substantial focus on offering case management support to people experiencing or at risk of homelessness who are leaving hospital and/or engaged in health services within the region.

The program, which is being delivered by Mission Australia, will target a range of outcomes, including acquiring stable accommodation and employment through intensive case management for up to two years.

The Constellation Project

The Constellation Project is a national partnership project seeking to end homelessness in a generation. Founding members of the project include Australian Red Cross, Mission Australia Centre for Social Impact and PwC. The Constellation Project was officially launched in October 2018 and will use a social labs methodology to identify priorities and prototype solutions.

Appendix 5

Roles and responsibilities of each partner agency

The health service system in this region is complex and multifaceted, consisting of:

- Local Health Districts (Sydney Local Health District and South Eastern Sydney LHDs)
- Hospital Networks (St Vincent's Health Network and Sydney Children's Hospital Network)
- 18 public hospitals
- 1 Aboriginal Medical Service
- headspace sites
- Over 2,400 General Practitioners
- Over 4,500 Allied Health Professionals
- Over 480 Practice Nurses (SHCN, 2018)

There are also a range of Health-funded NGOs working in this space.

South Eastern Sydney Local Health District

What we currently do

The South Eastern Sydney Local Health District is committed to achieving equity in health and well¬being. Improving health and access to healthcare among people experiencing homelessness is a high priority. The SESLHD Homelessness Health Strategy 2018-2021 guides the District approach to homelessness through the delivery of a framework that identifies key domains of action. These domains are:

- Flexible service delivery;
- Consumer engagement and co-design;
- Workforce capability;
- Information and knowledge; and
- Intersectoral collaboration.

Implementation of the *Strategy* is supported by an Implementation Committee with representation from staff and clinicians from services/facilities across the Health District. These services and facilities have identified priority domains of action relevant to their work and have committed to undertake a number of actions in relation to these across the lifespan of the *Strategy*.

The SESLHD Homelessness Health Program coordinates initiatives that aim to improve health outcomes for people experiencing or at risk of homelessness across the District. A key focus area for 2019 is the delivery of the Homelessness Health Training Workshop and In-Service package. The package operates in partnership with Kirketon Road Centre (KRC) Drug & Alcohol Services, Oral Health Services, HIV and Related Programs (HARP), the Equity Program and the Matthew Talbot Hostel and builds the capacity of SESLHD staff and clinicians to respond to homelessness. To date, over 120 SESLHD staff have attended the workshop or in-service training.

There are many services across the District who are committed to and have implemented models of care which have improved access and outcomes for people experiencing homelessness.

Some of the key services are:

KRC

- Primary health care model with integrated in-house drug & alcohol, mental health, blood borne virus and case management specialists;
- Delivery of primary health clinics in partnership with Specialist Homelessness Services (SHS) such as Edward Eager Lodge and Wayside Chapel;
- Dedicated Kirketon Road Centre Homelessness Unit- SESLHD North;
- Street-based outreach to engage clients in areas of rough sleeping or marginal housing; and
- Collaboration with key Health, government and NGO partners on both individual client care and intersectoral initiatives.

Drug & Alcohol Services

- Engaging and retaining people experiencing homelessness in the Opioid Treatment Program;
- Regular identification of response to homelessness and risks of homelessness through monthly psycho-social screening tools; and
- Increased capacity to provide outreach and care coordination to clients who face multiple barriers to engaging with or sustaining engagement in treatment (often including people who are already experiencing homelessness or who have tenancies at risk).

Oral Health Services

- Operation and delivery of the Special Needs Dental Service;
- Support from a welfare officer embedded in the Oral Health Service to provide flexible support and care coordination; and
- Partnership with Specialist Homelessness Services and St Vincent's Hospital to deliver oral health screening and referral pathways.

Sydney Hospital Homeless Opportunities in Presentations to ED (HOPE) Project

- Application of a homelessness 'flag' in EMR to improve collection of homelessness data;
- Development and implementation of a social risk screening tool; and
- Focus on workforce capability through regular in-servicing and the development of intersectoral relationships and referral pathways.

Mission Australia Clinic

- Outreach service of the Department of Homeless Health at St George Hospital providing health care to men residing at the Mission Australia Centre at Surry Hills;
- Consultant physician-led clinics;
- Nurse led medical and vaccination clinics;
- On-site nurse led liver screening; and
- Mental health clinics led by a consultant psychiatrist.

Our priorities for the future

SESLHD will continue focus on improving health access and outcomes for people experiencing and at risk of homelessness through the ongoing implementation and evaluation of the District Homelessness Health Strategy.

The delivery and implementation of the Intersectoral Homelessness Health Strategy will support the development of robust intersectoral partnerships that will aid collaborative service planning, delivery and evaluation.

The implementation of the NSW Homelessness Strategy will influence the delivery homelessness health related activities. SESLHD will continue to partner with relevant government and non-government agencies to support the design of suitable programs that improve health access and health outcomes.

Sydney Local Health District

Sydney Local Health District is located in the centre and inner west of Sydney and comprises the local government areas of City of Sydney (west), Inner West, Canterbury-Bankstown (Canterbury), Burwood and Strathfield. The District is highly populated covering 126 sq. kilometres with over 5000 residents per sq. kilometre. Sydney Local Health District is characterised by pockets of extreme advantage and disadvantage and has a large population of people who are homeless. The area covered by the District has approximately 47% of all boarding houses in NSW. This includes approximately 380 registered boarding houses (in 2015) and there is also estimated to be a further 200 un-registered boarding houses. There are four assisted boarding houses in the District with approximately 100 beds (of a total of 270 beds in NSW).

Collaborative and purposeful partnerships are a critical to integrated healthcare delivery, building capacity, streamlining care, promoting strategic support and strengthening health improvement.

SLHD partnerships are especially important to the model of care supporting the health and wellbeing of people experiencing, or at risk of, homelessness.

Healthy Strong Communities (HSC) is an inter-sectoral collaboration established in 2014 as a Premiers Service Delivery Reform priority. The Collaboration is based on a shared understanding that mental health issues are a key risk factor for developing homelessness and that stable housing is central to recovery for people with mental illness. Led by SLHD and Department of Communities and Justice, Healthy Strong Communities has a vision that people living with significant mental illness will be able to live in stable homes within safe, inclusive communities and receive better targeted and integrated services in the community. The collaboration includes 14 state and local government and non-government organisations representing health, community services, education, Corrections, police, the university sector and consumers.

The Collaboration has overseen an extensive program of work including

- Developing and refining place-based, multi-agency and person-centred services for people living in social housing;
- Coordinated wrap around supports for people living in Boarding Houses with severe mental illness; and
- An inter-sectoral submission to the Review of the NSW Boarding Houses Act.

Better Pathways to Housing program

Established in 2015, The Better Pathways to Housing (BPTH) is a multi-agency program to improve housing pathways for people with severe and enduring mental illness who often have poor housing outcomes and a reduced ability to navigate multiple, complex pathways. BPTH has focussed on 4 key areas across Mental Health supported accommodation, social housing, general boarding houses and rough sleepers to improve entry and exit pathways and tenancy management.

The Program has made significant achievements including:

- mapping and realignment of the range of supported housing including more integrated models and new step up/down high support housing models;
- developed partnerships with Community Managed Organisations to pilot new supported housing models utilising innovative funding strategies;
- an increase to 68 units (from 54) of Mental Health supported accommodation;
- Creating an integrated model of care linking psycho-social support to housing models;
- Implemented a new Housing Liaison role - a senior Mental Health clinician - working across Housing and Health to improve linkages, streamline processes and access;
- Developed an online, “live” data-base and portal for health workers to identify vacancies across supported housing and support packages;
- Piloted enhanced wrap around support models for people living in Boarding Houses;
- Coordinated outreach to rough sleepers;
- Initiated the Inner West hot-spot Street count in 2015; and
- Developed new pathways from supported housing into Public Housing.

Service Highlights

YouthBlock Youth Health Service based in Chippendale provides specialised clinical and health promotion services for at risk young people aged 12-24.

In addition to counselling and clinical (medical and nursing) services, YouthBlock provides emergency meal packs, outreach to youth refuges, Juvenile Justice, support accessing crisis accommodation and Centrelink to young people who are homeless or at risk of homelessness.

Sydney District Nursing and Child and Family Health Services provide unique and compassionate clinical services to people and families who are rough sleeping, living in Boarding houses or experiencing secondary homelessness.

The Camperdown Project, based on the successful Common Ground model from New York has operated in Camperdown since 2011. The project is a coordinated government response, providing permanent homes and onsite support services in 104 units for up to 52 former rough sleepers, 42 affordable and 10 social housing homes. SLHD Population Health, Mental Health and Drug Health have developed strong partnerships with Common Ground to facilitate easy access to a range of health services to assist people to access services and maintain their health and wellbeing. Common Ground has been highly successful and maintains over 95% occupancy and residents successfully managing their tenancy.

SLHD Population Health and Public Health partner with a range of community organisations including Exodus Foundation and Newtown Neighbourhood Centre to provide screening and treatment for a range of Blood Borne viruses and targeted flu vaccination clinics.

St Vincent's Health Australia, St Vincent's Hospital, Sydney

The St Vincent's Health Australia's (SVHA) strategy, EnVision 2025, outlines a program for growth and leadership over the coming years. EnVision 2025 will be the roadmap for the future of SVHA, demonstrating the shared commitment to continue the mission that underpins the work of the organisation. Throughout the implementation of this strategy SVHA will work to grow its presence and capabilities to strengthen the role it has in supporting those most in need, whilst continuing to pursue excellence across all our activities. St Vincent's Health Australia has five priority groups. This includes people experiencing homelessness, people experiencing poor mental health, people experiencing drug and alcohol issues, Aboriginal and Torres Strait Islander people and people leaving prison.

What we currently do

The St Vincent's Hospital, Sydney, Homeless Health Service is a multi-specialty service that uses a strengths-based, harm minimisation approach and aims to support people experiencing homelessness or at risk of homelessness to:

- Actively engage in healthcare;
- Access mainstream services of their choice;
- Partner with local services to provide assessment, treatment, education, care coordination, support and referral; and
- Identify their priorities and create strategies to achieve their goals.

There are several outreach-based teams and two residential facilities that fall under the umbrella of the Homeless Health Service. The Homeless Health Service Manager has oversight over the following teams:

Homeless Outreach Team

Uses a 'no wrong door' approach in responding to referrals to the Homeless Health Service. The team includes a nursing unit manager, mental health clinicians, social workers, an oral health educator, peers support worker, Aboriginal health worker, registered nurses and doctors including a general practitioner, psychiatric registrar, psychiatric consultant and co-morbidities specialist. The medical staff provide support to the entire Homeless Health Service. The team provides a range of clinics at local services and street based outreach to offer assessment, treatment, referral and care coordination to persons experiencing homelessness. The Homeless Outreach Team provide clinics at the Station Drop In Centre, Wayside Chapel including the WISH Hub, NSW Trustee and Guardian Client Specialist Centre, Vincentian House, Foster House, Edward Eager Lodge, Medically Supervised Injecting Centre, and Rankin Court Treatment Centre.

Assertive Outreach Team

Assist people experiencing primary homelessness to access mainstream and specialist health care and support whilst fostering access to housing and psychosocial support. Works in collaboration with clients, local service providers and communities to build and strengthen client support networks and assist clients onto a pathway out of homelessness. The team comprises of a health service manager, mental health clinicians, registered nurses and drug and alcohol clinicians.

Wesley Mission Partnership

Funded by Wesley Mission, it's a partnership between Wesley Mission and the Homeless Health Service. Two senior Homeless Health mental health clinicians are embedded within the Wesley Mission Therapeutic Support Team. The mental health clinicians provide support exclusively to the Wesley Mission team and clients of the service. The Wesley Mission Partnership covers 9 Local Government Areas.

After Hours Homeless Outreach Team

Funded by the Central and Eastern Sydney Primary Health Network. The team comprises of a nurse practitioner, clinical nurse consultant, Aboriginal health worker and peer support workers. They provide a range of physical health clinics within the St Vincent's Hospital Emergency Department as well as local services in the after-hours space, including afternoons and weekends. The After Hours Homeless Outreach Team provide clinics at Vincentian House, Edward Eager Lodge, Lou's Place and Samaritan House.

Tierney House

12 bedded short-term residential unit that assists people experiencing homelessness to access health care. Tierney House provides a safe and stable environment where residents can access assessment, treatment and support from St Vincent's Hospital and local services. The primary support staff includes a health service manager and residential support workers, all of whom have a wide range of skills and expertise in homelessness.

Stanford House

Funded through the Sydney Local Health District Non-Government Organisation Program. 4 bed residential unit that provides services for people living with HIV, who are homeless or at risk of homelessness. Its core services include supported accommodation for up to three months in a safe and secure environment, specialised support, linkage with external and internal health providers for facilitating ongoing support of HIV management (and its co-occurring issues), and outreach support to former clients. The primary support staff includes a health service manager and residential support workers with a wide range of skills and expertise in HIV.

The Homeless Health Service is a well-respected health service within the Inner City. St Vincent's Hospital, Sydney have strong partnerships with internal and external stakeholders and within the homelessness sector. These partnership are pivotal to the functioning of the service. Representatives from the Homeless Health Service attend various interagency meetings, forums, and collaborations on a weekly basis with the Department of Justice and Communities, City of Sydney Homelessness Unit and many of the Specialist Homelessness Services, with the collective goal to support people experiencing homelessness from a health, housing and psychosocial perspective. Some of the collaborations include the Homelessness Assertive Reponses Team (HART), Collaborative Support Initiative (CSI), Eastern Suburbs Homelessness Assertive Outreach Collaboration (ESHAC), Woolloomooloo Homelessness Case Coordination Group (WHCCG), and the District Homelessness Executive Group (DHEG). Other key relationships are with Local Health Districts, other non-government organisations inclusive of health and housing supports, police, ambulance and other specialists within St Vincent's Hospital, including our mental health and alcohol and other drugs colleagues.

Our priorities for the future

Future priorities for the Homeless Health Service include:

- St Vincent's Health Australia have developed a Health and Homeless Framework. This framework will guide the transformation of our services for those experiencing homelessness and those at risk of homelessness with a particular focus on those exciting care from St Vincent's Health Australia;
- Continuing to provide quality and safe healthcare to people experiencing homelessness or at risk of homelessness as well as offering housing and psychosocial support;
- Continuing to maintain strong partnerships with our internal and external stakeholders to work towards achieving desired goals;
- Providing quality and excellent health care that is underpinned by research and evidence-based care;
- Being at the forefront of innovative and holistic healthcare for people experiencing homelessness.

Central and Eastern Sydney Primary Health Network

CESPHN's vision is "better health and wellbeing for everyone living in our community". CESPHN is focused on achieving three strategic priorities; improving the quality of primary care, better integration of care, and commissioning services where they are needed. CESPHN supports GPs, general practices and other primary care providers to improve the quality of care in the community.

CESPHN works with GPs, other primary care professionals, and the broader health system to better integrate care for people who are homeless or at risk of homelessness.

Homelessness is identified as a key priority in the Central and Eastern Sydney PHN (CESPHN) Strategic Plan 2019-2021. CESPHN is committed to improving health, increasing access to coordinated health care, and working in partnership to achieve better outcomes for this vulnerable group, through the organisation's key strategies:

- **Improve practice** – supporting GPs and allied health providers to deliver quality care for people experiencing homelessness.
- **Integrate systems** – utilising a whole of systems approach to coordinate person-centred care for people experiencing homelessness.
- **Commission services** – invest in outcomes focused health services aimed at people experiencing homelessness.

What we currently do

- Advocacy at the State and Federal levels for equitable access to primary health care services for people who are experiencing homelessness and issues related to homelessness. This includes membership on key cross agency committees such as the:
    - Intersectoral Homelessness Health Strategy collaborative;
    - District Homelessness Executive Group; and
    - Healthy Strong Communities.
- Support primary care providers to make referrals and provide resources to people experiencing homelessness through HealthPathways;
- Implement strategies that will deliver integrated holistic and trauma informed care, and training and education to primary care providers;
- Commission services for people experiencing homelessness, or services that have a focus on equity of access for priority populations, such as:
    - Communities at the Centre, a place-based project in a social housing area of Maroubra that addresses the social determinants of health, including housing security and homelessness.
    - Diabetes Resource Collaborative that aims to ensure equitable diabetes services across the region, including services for priority populations, such as people experiencing homelessness;
    - Inner City Outreach Project, Kirketon Road Centre provides primary health care
    - Services to vulnerable populations, including people experiencing or at risk of homelessness in the CESPHN region; and
    - After Hours Primary Health Care to People Experiencing or at Risk of Homelessness, St Vincent's Hospital Sydney will deliver an After Hours Primary Care Health Service which involves a Nurse Practitioner and Peer Support Navigator building relationships with GPs and community managed organisations.

Our priorities for the future

Our focus will be on delivering equitable primary care services to people experiencing homelessness in the region.

Key opportunities include:

- Building workforce capacity to provide trauma informed primary health care;
- Working with GPs and Allied Health care providers to provide enhanced care opportunities for those who are homeless or at risk of homelessness;
- Supporting mechanisms for sharing of health data across primary health care and acute services to facilitate the provision of holistic, integrated care; and
- Commissioning models of service that improve equitable access to health care for people experiencing homelessness;

We will continue to update the CESPHN needs analysis to identify gaps in care and commission services where are they are most needed. Additionally, CESPHN will continue to engage with key stakeholders includes LHDs/SVHN and CESPHN Community Council and Clinical Council to identify and advocate for opportunities to enhance policy settings and service provision in the area of homelessness.

Department of Communities and Justice: Sydney, South Eastern Sydney and Northern Sydney (SSESNS) District

What we currently do

The Department of Communities and Justice (DCJ) works with children, adults, families and communities to improve lives and help people realise their potential. We collaborate with our government and non-government partners and local communities to focus on prevention, where possible, while providing targeted assistance to those most in need.

Homelessness Outreach Support Team (HOST)

The HOST was established in 2017 to provide immediate access to housing assistance for people sleeping rough. The team works in partnership with homelessness services, local Councils, Health, Police and Transport NSW to provide intensive and regular outreach patrols, housing assessment and support, and a rapid rehousing response for people eligible for social housing who are willing to work with DCJ and support services.

The HOST works with homelessness support providers and Health to wrap post-crisis support around those clients who have been housed and need more sustained support.

The HOST works with the City of Sydney and St Vincent's Homeless Health in the delivery of the Emergency Response Protocol, including responding to extreme weather conditions to people sleeping rough.

Local Housing Teams

Local Access and Demand teams provide access to housing support for people eligible for social housing. DCJ can provide access to Temporary Accommodation and Supported Temporary Accommodation, housing products and social housing. Local Tenancy teams manage all social housing tenancies in their area. Senior Client Services Officers are located within these teams to support clients with more complex needs to access housing and sustain their tenancy.

Specialist Homelessness Services

DCJ will allocate a total of $61 million in 2019/20 to more than 30 organisations in the Sydney and South Eastern Sydney districts to provide support and accommodation services to people who are experiencing homelessness or at risk of becoming homeless. Specialist homelessness services support women, men, young people, families, Aboriginal people and people from culturally and linguistically diverse backgrounds. They help women experiencing domestic and family violence, people who are sleeping rough, young people leaving care, people with mental health issues, people living in unsafe conditions, older people, and people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex or Queer (LGBTIQ). Specialist homelessness services are delivered by non-government organisations.

Assertive Outreach Coordination and Case Coordination groups

DCJ supports the implementation of case coordination collaborative groups across Sydney and South Eastern Sydney. These groups support people sleeping rough to exit homelessness, and to access ongoing health care and long-term housing with support.

Groups in Sydney and South Eastern Sydney include:

- Homelessness Assertive-outreach Response Team (HART), covering the City of Sydney LGA;
- Collaborative Support Initiative (CSI), for complex clients in the inner city area;
- Woolloomooloo Integrated Services Hub (WISH), coordinating services for people sleeping rough in the Woolloomooloo area;
- Newtown Homelessness Assertive Outreach Collaboration (NHAOC), covering the suburb of Newtown and surrounding area;
- Ashfield Homelessness Assertive Outreach Collaboration (AHAOC), covering Ashfield;
- Eastern Suburbs Homelessness Assertive-outreach Collaboration (ESHAC), covering Waverley and Woollahra LGAs; and
- Discussions are being held with homelessness services and local Council to establish a collaborative group in the Sutherland Shire.

Our priorities for the future

NSW Homelessness Strategy 2018–2023

In 2018, DCJ released the NSW Homelessness Strategy 2018–2023, which sets out the NSW Government's five year plan for a comprehensive approach to preventing homelessness and improving the way we respond to homelessness so that fewer people experience homelessness, and people are empowered to tackle the issues that put them at risk of homelessness.

The scope of the strategy recognises that a person's pathway into homelessness is driven by the intersection of structural drivers, risk factors, and protective factors. As such it has three key focus areas for action:

Focus 1: Prevention and early intervention;

Focus 2: Better access to support and services; and

Focus 3: An integrated, person centred system.

Premier's Priority to reduce homelessness

In June 2019, the NSW Premier announced that reducing homelessness was one of the 14 Premier's Priorities. The NSW Government has set a target of reducing street homelessness by 50 per cent across NSW by 2025. DCJ is the lead agency responsible for delivering on this Priority. This commitment is part of a global initiative to reduce street homelessness and builds on the Act to End Street Sleeping (Vanguard) Agreement in the City of Sydney Local Government Area, signed by the NSW Government, City of Sydney, Institute of Global Homelessness and seven NGO partners in February 2019.

City of Sydney

What we currently do

The City was the first Local Government in Australia to have a dedicated homelessness unit. The City's Homelessness Unit is a leader in providing and coordinating innovative, evidence-based responses to reduce homelessness and its impact in Sydney. This includes coordinating the biannual street count, which tracks the number of rough sleepers in the city, hosting quarterly homeless interagency meetings to build the capacity of the sector, conducting research and advocacy to influence policy, and engaging and coordinating services to harness the capacity of the sector and the community to share resources, skills and knowledge to address this complex social issue.

The City of Sydney invests $2.2M every year to reduce homelessness and its impact in Sydney, including providing grants for the provision of homelessness services.

Responding to Issues of Homelessness in the Public Space

The City employs Public Space Liaison Officers, (PSLOs) who work across seven days engaging people who are sleeping rough in the city and connecting them to services. PSLOs also engage with local residents and businesses to increase understanding and resolve problems before conflict arises. PSLOs build professional relationships and provide links to essential services. This work is done in accordance with the NSW Homeless Protocol for Homeless People in Public Places.

The City, together with NSW Department of Communities and Justice (DCJ), coordinates a specialist outreach team, the Homelessness Assertive Outreach Response Team, (HART). The purpose of the HART is to share skills, resources and knowledge among specialist services to support people sleeping rough in Inner City Sydney to exit homelessness, access ongoing health care and long-term housing with support.

Emergency Response to Extreme Weather

Following a partnership response to extreme storms in April 2015, the City of Sydney and NSW Department of Communities and Justice established the Emergency Response Protocol for Rough Sleepers in Sydney to oversee the coordination and provision of accommodation and other services for people sleeping rough in the City of Sydney LGA in an emergency. The most common activation is during extreme heat where, water and sunscreen are distributed, health checks are conducted, and people are informed about places to go to keep cool.

Mobile Voluntary Services

Mobile voluntary services (e.g. charity food vans), are an important element within the range of services provided to people experiencing homelessness and other disadvantaged groups in the inner city. They operate at a time when many other services are unavailable, offering food, blankets, clothes, hygiene and personal services, social contact and spiritual support.

The number of mobile voluntary services operating has been increasing. With this increase, there has also been a rise in amenity issues and resident complaints about noise and rubbish in particular, as well as concerns about safety and healthiness and of food. The City is working with key partners including NSW Family and Community Services, NSW Police Force, NSW Health and the NSW Food Authority to address these issues. In 2019, the City conducted research into the provision and use of mobile voluntary services in order to better understand need.

Appendix 6
Project Governance

Steering Committee members

Greg Stewart, Director, Primary Integrated and Community Health, SESLHD (Chair)

Alison Sneddon, Senior Health Services Planner, Manager, Strategy, Innovation and Improvement, SESLHD

Brendan Goodger, General Manager, Primary Care Improvement, CESPHN

Christine McBride, Manager Social Programs and Service Administration, City of Sydney

Dominic Le Lievre, Director, Integrated Care, St Vincent's Health Network

Jon Swain, Manager, Homelessness, City of Sydney

Lisa Parcsi, Manager, Integrated Care, Clinical Services Integration, SLHD

Lisa Woodland, Manager, Priority Populations, SESLHD

Lou-Anne Blunden, Executive Director Clinical Services Integration and Population Health, SLHD

Matt Larkin, Manager, Homeless Health Service Manager, St Vincent's Hospital

Penny Church, Director, Commissioning and Planning, Department of Communities and Justice

Rebecca Sarkies, A/Manager, Homeless Health Service, St Vincent's Hospital

Stephanie MacFarlane, Homelessness Health Program Manager, SESLHD

Thuy-Vi Le, Manager Homelessness, Department of Communities and Justice

Tony Jackson, Deputy Director, Population and Community Health, SESLHD